POC accepted 2/11/09 B. Carlson's letterhead.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295050	A. BUILDING _____ B. WING _____	01/29/2009

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LIFE CARE CENTER OF RENO	445 W. HOLCOMB LANE RENO, NV 89511

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of an annual Medicare recertification survey conducted at your facility on 1/26/09 through 1/29/09. The census was 172 residents. The sample size was 28 residents. Complaint #NV00020738 was investigated. The complaint was substantiated with a deficiency cited (F309). The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. RECEIVED FEB 20 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	
F 168 SS=D	483.10(g)(2) EXAMINATION OF SURVEY RESULTS A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to post state agency contact information for all residents and specifically for 1 of 28 residents (#26). Findings include:	F 168	**F 168** I) Resident #26 has been discharged from the facility. While Resident #26 was residing at Life Care Center of Reno, there were 6 "Help us to Serve You" posters posted in prominent places throughout the facility that contained the government agency known as Elder Protector Services including the phone number. Bureau of Licensure and Certification (BLC) with phone number was added to the posters on January 28, 2009 during the survey so that current residents would have the information available to them.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Machelle Harris	Executive Director	2/20/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 168	Continued From page 1 Resident #26 was admitted on 7/15/08, with diagnoses including fractured neck of femur, closed fracture of the phalanx, diabetes mellitus, and muscle weakness. Resident #26's record review revealed that the resident was admitted to the facility for rehabilitation for difficulty with mobility and walking related to her non-weight bearing status of the right lower extremity. She required a bedside commode for elimination. Resident #26 was interviewed and reported that the facility failed to provide a bedside commode for her to use in a timely manner. The resident further reported that she wanted to file a complaint against the facility, but was unaware that the state agency existed. Tour of the facility on 1/26/09, revealed no evidence that the state agency's contact information was posted. On 1/27/09 at 1:30 PM, the Director of Nurses was interviewed and reported that the state agency's information was not posted any where in the facility. Cross-reference F 309	F 168	II) Current residents had the potential to be affected by the alleged practice. III) BLC phone number has been added to the posters and is posted in prominent places around the facility. IV) Manager on Duty on weekends completes a "Customer View" form to ensure cleanliness and that state/federal guidelines are being met. The presence of the "Help us to Serve You" posters has been added to the form to ensure their presence. See exhibit 1. Randomly, during regular business day, the Executive Director or designee will validate state agency's information is posted. Findings will be submitted to Performance Improvement Committee for the next 3 months. See exhibit 2. V) Executive Director VI) March 13, 2009	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy and procedure review, the facility failed to ensure that	F 281		

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F 281	Continued From page 2 services were provided in accordance with facility policy and procedures and professional standards of quality for 2 of 28 residents (#3, #27). Findings include: Resident #3 had a gastrostomy tube for nutrition and medication administration. On 1/27/09 at 8:10 AM, a registered nurse (RN) was observed giving medications to Resident #3 via the gastrostomy tube. The RN was observed to stop the feeding, attach a syringe to the gastrostomy tube, and administer the medications via the syringe. The RN was not observed to check placement of the gastrostomy tube prior to the administration of medications. On 1/27/09 at 8:15 AM the RN was interviewed. She stated that she did not usually check placement of the gastrostomy tube prior to administering medications or tube feeding. She stated that she did not know that checking the placement was supposed to be done. On 1/27/09 at 9:00 AM, the Director of Nurses was interviewed. She stated that it was the facility policy to check placement of a gastrostomy tube prior to administering feeding formulas or medications. On 1/27/09, at 9:30 AM, the facility policy and procedure for "Feeding Tube - Instilling Medication" was reviewed. Per the procedure step 6: "Attach syringe to end of the tube and insert 20 cc of air. a. Check placement and patency by auscultation. b. If tube is not adequately placed, do not give the medication and do not flush with water, but	F 281	**F 281** I) Resident #3 has G-tube placement checked prior to medication administration. Resident #27 has heart rate checked and noted on MAR prior to medication administration. Medical Provider parameters are followed prior to administration of medications. II) Other residents with g-tubes have been assessed and have their tube placement checked prior to medication administration. Other residents with medications requiring the heart rate being checked prior to administration have been assessed. Heart rates are being documented prior to administration and medications are held if heart rate is not within established parameters. III) Admission Orders have been amended to include "Check placement of tube prior to administering medications via g-tube. See exhibit 3. Nursing staff to be in-serviced in regards to checking placement prior to administering medication in a g-tube per Life Care Center of Reno's policy. Nursing staff to be in-serviced in regards to noting heart rates on the Medication Administration Record prior to administering the medication and holding the medication if the heart	

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F 281	Continued From page 3 adjust placement of feeding tube or insert a new one." Cross reference F 322 Resident #27 had an order for Amiodarone 100 milligrams (mg) by mouth daily and to "hold if heart rate less than 60." On 1/27/09 at 8:00 AM, a RN was observed administering the medication during a medication pass. The RN checked the resident's heart rate (HR) and proceeded to administer the medication. The RN then documented a HR of 57 in the Medication Administration Record (MAR). On 1/27/09, the RN 14 was interviewed. She stated she always checked Resident # 27's HR, but gave the medication before she read the parameters for holding the medication. The RN stated she only documented the HR on the MAR if it was below 60. Review of Resident #27's MAR for the month of December 20008 revealed no HR documentation listed on the MAR. Review of the MAR for January 2009 revealed one HR recorded on 1/17/09 of 53 and "hold" was written on the MAR. On 1/27/09, at 9:15 AM, an interview was conducted with the Director of Nurses. She stated "nursing should be recording the heart rate on the MAR each day per the physician order." Review of the facility policy and procedure for "Medication Administration" item 20 revealed that medications that require parameters are charted in the MAR. Cross reference F 329	F 281	rate is not within the established parameter. See exhibit 4. IV) Resident Care Managers or designee will perform a random audit weekly to ensure that residents with G-Tubes have placement checked prior to administration of medications. See exhibit 5. Resident Care Managers or designee will perform a random audit weekly to ensure that heart rate is documented on Medication Administration Record prior to administration of medication and that the medication is held if heart rate is outside of parameters. See exhibit 6. Audit results to be reported to the Performance Improvement Committee monthly until threshold is met. See exhibits 7 & 8. V) Director of Nurses VI) March 13, 2009	

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide necessary rehabilitation equipment in a timely manner for 1 of 28 residents (#26). Findings include: Resident #26 was admitted to the facility on 7/15/08 at 12:26 PM, with diagnoses including right trochanteric femur fracture with open reduction and internal fixation, and a closed fracture of the phalanx. The resident was admitted for intensive rehabilitation. The resident was 59 years old, alert and oriented. Resident #26's record review revealed an entry into the nurses notes dated 7/16/08 at 1:00 PM that read: "commode in room." Resident #26 was interviewed and reported that the facility failed to provide a bedside commode for her to use within the first day of her admission. She reported that her sister had purchased one for her to use in the facility. She reported that the facility did provide a commode on 7/16/08. Resident #26 further reported that she was told by facility staff to use a bedpan and that a	F 309	**F 309** I: Resident #26 has been discharged from the facility. II: Residents admitted to the facility within the month of January have been assessed for and provided needed rehabilitation equipment. III: Nursing, Admission, and Central Supply staff will be in-serviced regarding the importance of providing needed equipment in a timely manner upon admission. See exhibit 4 & 9. IV: Resident Care Managers or designee to audit random new admissions to ensure timely provision of equipment. See exhibit 10. Performance Improvement Committee will review monthly until threshold is met. See exhibit 11. V: Director of Nurses VI: March 13, 2009	

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F 309	Continued From page 5 bedside commode was not available. A registered nurse (RN) was interviewed on 1/26/09 at 1:00 PM, and reported that she recalled that Resident #26 "was not happy at the facility no matter what staff did to please her." She reported that she did not remember when the commode was placed in the resident's room. On 1/26/09 at 1:15 PM, a second RN was interviewed and reported that the bedside commode is usually placed in the resident's room "right away." He reported that a commode would be available at the facility and was kept in a storage area on the unit. He also reported that the facility staff often wait for the resident to have a physical therapy evaluation prior to providing any equipment. He also reported that the staff commonly offer a resident a bedpan if they have not had a physical therapy evaluation. He further reported that there was no written policy related to providing equipment in a timely manner. On 1/28/09 at 2:50 PM, the central supply clerk was interviewed and reported that the facility had bedside commodes stored on the units available for use. Review of the Resident #26's acute care facility record revealed that the nurses notes and case management notes referred to the need for, and the resident's use of, a bedside commode in numerous entries throughout the record. The physician's discharge summary dated 7/15/08, read: "At discharge, she is ambulatory." Cross reference F 168	F 309		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES	F 322		

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F 322	Continued From page 6 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure nursing checked the placement of a gastrostomy tube prior to administering medications for 1 of 28 residents (#3). Findings include: Resident #3 had a gastrostomy tube for nutrition and medication administration. On 1/27/09 at 8:10 AM, a registered nurse (RN) was observed giving medications to Resident #3 via the gastrostomy tube. The RN was observed to stop the feeding, attach a syringe to the gastrostomy tube, and administer the medications via the syringe. The RN was not observed to check placement of the gastrostomy tube prior to the administration of medications. On 1/27/09 at 8:15 AM the RN was interviewed. She stated that she did not usually check placement of the gastrostomy tube prior to administering medications or tube feeding. She stated that she did not know that checking the placement was supposed to be done. On 1/27/09 at 9:00 AM, the Director of Nurses	F 322	**F 322** I) Resident #3 has placement checked prior to medication administration. II) Other residents with g-tubes have been assessed and have their tube placement checked prior to medication administration. III) Admission Orders have been amended to include "Check placement of tube prior to administering medications via g-tube. See exhibit 3. Nursing staff to be in-serviced in regards to checking placement prior to administering medication in a g-tube per Life Care Center of Reno's policy. See exhibit 4. IV) Resident Care Managers or designee will perform a random audit weekly to ensure that residents with G-Tubes have placement checked prior to administration of medications. See exhibit 5. Audit results to be reported to the Performance Improvement Committee monthly until threshold is met. See exhibit 7. V) Director of Nurses VI) March 13, 2009	

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F 322	Continued From page 7 was interviewed. She stated that it was the facility policy to check placement of a gastrostomy tube prior to administering feeding formulas or medications. On 1/27/09 at 9:30 AM, the facility policy and procedure for "Feeding Tube - Instilling Medication" was reviewed. Per the procedure step 6: "Attach syringe to end of the tube and insert 20 cc of air. a. Check placement and patency by auscultation. b. If tube is not adequately placed, do not give the medication and do not flush with water, but adjust placement of feeding tube or insert a new one." Cross reference F 281	F 322		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 28 residents maintained acceptable weight parameters (#11).	F 325	**F325** I. Resident #11 is on weekly weights and weight is currently stable. It should be noted that the surveyor requested and was provided a copy of the quarterly review dated 6/16/08 in the Nutritional Progress Notes. See exhibit 12. Also in the chart is an Annual Nutritional Data Collection/Assessment form that was completed on 9/5/08. See exhibit 13. This form is completed annually in place of the quarterly review. A quarterly review is noted on 12/5/08 in the following Nutritional Progress Notes. See exhibit 14. The following interventions were implemented throughout the year: • On 11/13/07 whole milk was added due to 4.5# loss • On 1/11/08 the physician progress notes indicate unavoidable weight	

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F 325	Continued From page 8 Findings include: Resident #11 was admitted to the facility 9/28/06 and readmitted on 10/31/07 with diagnoses including muscle weakness, Parkinson's disease, dementia, hypertension, anemia, hypothyroidism, and psychosis. A review of Resident #11's weight record revealed his admission weight on 10/31/07 was 156 pounds which was in his ideal body weight range of 139 to 169 pounds. The weight record revealed a progressive weight loss over the last year of 14.4 pounds. The resident was on monthly weights over the last year except for one month where his weight loss triggered intervention and weekly weights. The last full dietary assessment was dated 9/5/08. Resident #11's weight at that time was 147 pounds. The weight record indicated the resident weighed 138.9 pounds on 11/4/08, 136.4 pounds on 12/9/08, and 135.9 pounds on 1/5/09. There were no dietary progress notes from 6/3/08 to 1/5/09. The dietary progress note from 1/5/09 indicated the facility would add health shakes twice per day to Resident #11's dietary regimen. A review of the medical record indicated Resident #11 was found to have a scrotal wound on 12/3/08. Although the wound was healed within two weeks, the discovery of the wound did not prompt any dietary interventions. An interview with the dietician on 1/27/09 at 1:00 PM revealed there was no written criteria for placing a resident on weekly weights, and that the decision was a judgement call. When it was pointed out Resident #11 was still on monthly	F 325	loss. • On 6/3/08 2Cal Med Pass was initiated due to a 6.8# loss. • On 10/31/08 Albumin was assessed to be within normal range. • On 1/6/09 Health Shakes were added due to a 0.5# loss. • On 1/27/09 weekly weights were implemented. • Intake has remained 95-100% consistently throughout this period. See exhibits 15 & 16. II. Weights will be audited for gradual loss and interventions implemented. Residents with actual skin integrity issues will be reviewed to validate that dietary interventions have been implemented. Charts to be audited for quarterly assessments. See exhibit 17. III. Nursing, dietician, and diet tech will be educated to monitor for gradual weight loss and to implement interventions as necessary. In addition, education will be provided regarding nutritional interventions for residents with actual skin integrity issues. See exhibit 4 & 18. IV. Dietician or designee to perform random audit observing for gradual weight loss monthly. See exhibit 19. Weekly, Treatment nurse or designee will audit residents charts with actual skin break down to validate nutritional interventions are in place. See exhibit 20.	

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F 325	Continued From page 9 weights and was below his ideal body weight range for the last three months, the dietician agreed the resident should be on weekly weights. A review of the manual of "Nutrition Assessment and Documentation" supplied by the corporation, revealed a policy which stated residents who have a significant weight variance are evaluated and approaches are implemented per resident as needed. Under guidelines the policy stated residents with weight and/or intake concerns are evaluated according to the facility's guidelines. The dietician indicated there were no written facility guidelines for weight and intake management or criteria for determining timing of interventions.	F 325	Audit results to be reported to the Performance Improvement Committee monthly until threshold is met. See exhibit 21 & 22. V. Dietician IV. March 13, 2009	
F 329 SS=D	483.25(I) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	**F329** I: Resident #27 has heart rate noted on MAR prior to medication administration. Resident # 16 has been discharged home. II: Residents will be audited for unnecessary drugs. Residents receiving medication requiring monitoring of heart rate with parameters prior to administration of medication has the potential to be affected the alleged practice. III: Nursing will be educated regarding importance of monitoring heart rate prior to administering medication as indicated in order to prevent administration of unnecessary drugs.	

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F 329	Continued From page 10 drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that each resident's medication regimen was free of unnecessary drugs for 2 of 28 residents (#27, #16). Findings include: Resident #27 had an order for Amiodarone 100 milligrams (mg) by mouth daily and to "hold if heart rate less than 60." On 1/27/09 at 8:00 AM, a RN was observed administering the medication during a medication pass. The RN checked the resident's heart rate (HR) and proceeded to administer the medication. The RN then documented a HR of 57 in the Medication Administration Record (MAR). On 1/27/09, the RN 14 was interviewed. She stated she always checked Resident # 27's HR, but gave the medication before she read the parameters for holding the medication. The RN stated she only documented the HR on the MAR if it was below 60. Cross reference F 281 Resident #16 was admitted on 1/14/09, with diagnoses including lumbar laminectomy and fusion, lumbar spinal stenosis, history of two cerebrovascular accidents and urinary tract infection.	F 329	Education will include the importance of timely monitoring and notification of lab results in order to prevent administration of unnecessary drugs. See exhibit 4. Infection control nurse or designee will review antibiotic orders to validate necessity and will coordinate care with Medical provider. Pharmacy consultant will audit for unnecessary drugs on a monthly basis and supply a report to the Director of Nurses. VI: Audit results to be reported to the Performance Improvement Committee monthly until threshold is met. See exhibit 23. V: Director of Nursing VI: March 13, 2009	

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F 329	Continued From page 11 Resident #16's record review revealed that an entry made in the nurses notes dated 1/18/09 at 1:00 AM, indicated that the resident had "multiple" episodes of diarrhea. Record review revealed that on 1/18/09, the resident had been started on an antibiotic for a possible clostridium difficile (C-diff) infection. On 1/19/09, a stool culture was ordered. Resident #16's record review revealed that a lab report received by the facility on 1/20/09 at 2:00 PM, indicated that the resident did not have a C-diff infection. Further review of Resident #16's record revealed that the physician ordered the antibiotic to be discontinued on 1/26/09. The Resident Care Manager (RCM) was interviewed and reported that the lab report should have been placed in the "communication book" for the physician to review the following day. She reported that a nurse should have called the physician because she was being treated with antibiotics with no indication.	F 329		
F 364 SS=B	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, the facility did not ensure its food was served at the proper temperature.	F 364		

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F 364	Continued From page 12 On 1/27/09 at 12:10 PM the following temperatures on a test tray were obtained at the Denton building kitchen, just after it had been placed on the cart to be delivered: barbecue beef -110 degrees Fahrenheit (F); baked beans -90 degrees F; coleslaw -52 degrees F; custard pie -50 degrees F. On 1/28/09 at 12:15 PM the following temperatures on a test tray were obtained at the Denton building: soup -122 degrees F; pork -120 degrees F; baked potato -130 degrees F; cooked cauliflower -110 degrees F; sour cream -50 degrees F. The soup was observed already poured in bowls with lids, sitting on the tray line, before the trays were assembled. The dietary manager stated that the kitchen's normal procedure was to put the soup in bowls at the time each tray was assembled. The dietary manager stated that the kitchen's policy was for hot food to be delivered at a temperature of at least 140 degrees F, and that cold food was to be delivered at a temperature of 40 degrees F or below. During the group interview on 1/28/09 at 10:00 AM, four residents stated that hot food was sometimes served colder than desired at the dining rooms. The guidelines developed by the corporate office stated that "Food temperatures are checked before serving; if issues are identified, they are corrected, or the food is discarded."	F 364	**F 364** I: Food found to be outside proper temperature ranges during survey time was discarded and replaced. II: Residents who eat meals at Life Care Center of Reno have potential to be affected by this alleged practice. Therefore, temperatures are being monitored by the cooks during meal time. Food outside proper temperature range is heated, cooled, or replaced. III: The dietary staff has been educated regarding proper temperature ranges. They have been instructed to heat, cool, or replace food that is found to be outside proper temperature ranges. See exhibit 24. IV Director of Dietary will audit temperature logs and randomly test food trays for proper temperatures weekly. See exhibit 25. Audit results will be submitted to the Performance Improvement Committee monthly until threshold is met. See exhibit 26. V: Director of Dietary VI: March 13, 2009	
F 371	483.35(i) SANITARY CONDITIONS	F 371		

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F 371 SS=B	Continued From page 13 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, the facility did not ensure food was stored and prepared under sanitary conditions. Findings include: An inspection of the facility's two kitchens on 1/26/09 revealed the following: Main kitchen - Refrigerator: a container of prepared ham au gratin was undated; opened bags of shredded mozzarella and cheddar cheese were undated. Equipment: scaling/yellowing was noted on the interior rim of the ice machine; food particles were present on the slicer even after regular sanitizing; the dish hood was soiled and moldy; the back surfaces of the oven and surrounding floor were soiled. Satellite (Denton) kitchen - Refrigerator: an opened bag of shredded mozzarella cheese was undated; an opened container of cottage cheese was undated; prepared ham and cheese sandwiches were undated. Freezer: an opened bag of meatballs was undated. Equipment: the	F 371	**F371** I: Food that was found to be unlabeled during the time of survey was discarded immediately. The ice machine, slicer, dish hood, oven, and floor have been deep cleaned. II: Residents have the potential to be affected by unlabeled food and unsanitary equipment. Currently, food is properly labeled and equipment is clean. III: The dietary staff has been educated regarding the importance of labeling food and thoroughly cleaning equipment. See exhibit 24. Cleaning schedules are in place to ensure timely cleaning of equipment. IV: Director of Dietary will perform random weekly audits food labeling and equipment sanitation. See exhibit 25. Audit findings will be reported to Performance Improvement Committee monthly until threshold is met. See exhibit 27. V: Director of Dietary VI: March 13, 2009	

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F 371	Continued From page 14 dish hood was soiled and moldy. The dietary manager stated that the kitchen's policy was to date all leftovers and opened containers of potentially hazardous foods. The cold food storage guidelines developed by the facility's corporate office stated that "Leftovers are dated properly and discarded after 72 hours unless otherwise indicated."	F 371		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review the facility failed to follow up on residents with infections, or suspected infections, and the facility failed to establish an infection control program that investigated, controlled or prevented infections for 5 of 28 residents (#16, #20, #21, #22, #28). Findings include: Review of the facility's infection control log book revealed that the facility did not have a surveillance program to track or trend infections	F 441	**F 441** I: Resident #16 has been discharged home. Resident #20 was provided a private room. Resident #21 is in a private room. Resident #22 is in a private room. Resident #28 has a new roommate without an infection. II: Residents with infections have been assessed for proper precautions. III: Nursing staff will be educated regarding Life Care Center of Reno's Infection Control policy with special emphasis on contact precaution techniques and room assignments in order to more effectively prevent the spread of infection. See exhibit 4.	

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F 441	Continued From page 15 that are acquired in the facility. The "Infection Log" listed six nosocomial infections and two community acquired infections for the month of January. A document titled: "Line Listing of Patient Infections," listed 17 infections that were acquired in the facility in the month of January and one community acquired infection that did not meet the McGeer criteria. Research revealed that The Centers for Disease Control and Prevention (CDC) definitions for health care-associated infections (HAIs) were developed for hospitals and are generally not applicable to nursing homes. In 1991, McGeer et al developed a set of definitions for determining HAIs in long-term care. The criteria were developed by modifying the CDC definitions and taking into consideration the difference in population, services and resources. The criteria set forth was developed in accordance with the requirements of Act 52, using McGeer criteria and further modification of the CDC based criteria. On 1/28/09 at 3:30 PM, the Infection Control Nurse (ICN) was interviewed and reported that the facility only tracks community acquired infections and nosocomial infections which are defined as having met the McGeer criteria. She reported that any nosocomial infections that do not meet the McGeer criteria are not tracked or trended. She further reported that the facility does not discuss "other" infections in performance improvement meetings. She reported that the infections are treated but that no surveillance is done, and no measures are taken to control or prevent the spread of "other" infections. On 1/28/09 at 3:35 PM, the corporate nursing	F 441	Infection Control Nurse has included the trending of infections that do not meet the criteria of an infection according to McGeer. Infection Control Nurse to attend the Clinical Stand Up meeting for more effective monitoring of new infections, more timely interventions being implemented, and more accurate tracking and trending of infections. During business working days, Infection control nurse or designee will track and trend active infections, will maintain a record of incidents and corrective actions related to infections to insure appropriate investigation, control and preventative measures are in place. IV: Infection Control Nurse or designee to do random weekly audits of Contact Precaution techniques as carried out by staff, appropriate room assignments, and thorough tracking and trending of infections. See exhibits 28 & 29. Audit findings to be reported to Performance Improvement Committee on a monthly basis until threshold is reached. See Exhibit 30. V: Director of Nurses. VI: March 13, 2009	

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F 441	Continued From page 16 representative reported that the facility's infection control program should include tracking, trending, and steps toward control and prevention of all infections. Review of the facility's "Infection Control Program" book read: Chapter 1 -Goals of the Infection Control Program -Reduce acquisition and transmission of healthcare associated infections -Monitor for any occurrences of infection and implement appropriate control measures -Identify and correct problems relating to infection control practices -Ensure compliance with state, Federal, and OSHA regulations and JCAHO standards Chapter 2 - Surveillance of Infections read: "Purpose - To have knowledge of resident and associate infections so appropriate actions/follow-up may guide prevention activities. Policy: The infection control nurse does surveillance of infections among residents and associates by: -Reviewing culture reports and other pertinent lab data -Consulting with the nurses and referral -Reviewing charts -Reviewing infection control communication Form or 24 hour report -Following up on communicable disease exposure -Consulting with licensed independent practitioners Resident #16 was admitted on 1/14/09, with diagnoses including lumbar laminectomy and fusion, lumbar spinal stenosis, history of two	F 441		

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F 441	Continued From page 17 cerebrovascular accidents and urinary tract infection. Resident #16's record review revealed that an entry made in the nurses notes dated 1/18/09 at 1:00 AM, indicated that the resident had "multiple" episodes of diarrhea. Record review revealed that on 1/18/09, the resident had been started on an antibiotic for a possible clostridium difficile (C-diff) infection. On 1/19/09, a stool culture was ordered. Resident #16's record review revealed that a lab report received by the facility on 1/20/09 at 2:00 PM, indicated that the resident did not have a C-diff infection. Further review of Resident #16's record revealed that the physician ordered the antibiotic to be discontinued on 1/26/09. Resident Care Manager (RCM) #4 was interviewed and reported that the lab report should have been placed in the "communication book" for the physician to review the following day. She reported that a nurse should have called the physician because she was being treated with antibiotics with no indication. She further reported that she did not know why the lab report was missed. When asked what was the facility's policy related to physician notification of lab reports, she reported that the use of the communication book was not in a written policy, but that the nurses know that they are to use the book, or call the physician if necessary. Cross reference F511 Resident #22 was admitted to the facility on 1/21/09 with diagnoses that included	F 441		

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F 441	Continued From page 18	F 441		

rehabilitation, difficulty in walking, muscle weakness, chronic osteomyelitis, diabetes mellitus, acute renal failure, and congestive heart failure.

Resident #21 was admitted to the facility on 1/12/09 with diagnoses that included rehabilitation, difficulty in walking, muscle weakness, cerebrovascular accident, dysphagia, pneumonia, urinary tract infection, and staphylococcus aureus.

On 1/26/09, the initial tour was completed on the 300 hall where Residents #21 and #22 lived. Resident #22 was observed to be in an infections precautions room, with a Stop sign advising visitors to report to the nursing station before entering. The RCM conducting the tour explained that Resident #21 in bed number two was in respiratory precautions for Methicillin resistant staphylococcal aureus (MRSA) in his sputum. He stated that the facility followed Center for Disease Control (CDC) recommendations for respiratory precautions. He stated that according to the CDC, as long as the curtain remained pulled and Resident #22 was not within three feet of the roommate, there was not a problem of transmission. He did not identify Resident #22 as having any acute infection.

Review of Resident #22's medical record revealed a pre-admission billing diagnoses form completed by the sending facility that listed "MRSA, urine. Isolation?" Review of the laboratory tests revealed a wound culture done on 12/29/08 that was positive for MRSA. A nasal MRSA admission screen done on 12/31/08 was negative. Further review of laboratory testing for Resident #22 failed to reveal any other positive

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F 441	Continued From page 19 MRSA test. On 1/27/09, during the medication pass, the medication nurse identified that Resident #22 had MRSA of a wound on his foot. Resident #22's medical record was reviewed. Review of the nurses notes on 1/21/09, the resident was admitted to the room and had a Foley catheter intact upon admission. The nurse documented at 9:00 PM that Resident #22 was "on isolation for MRSA in urine." On 1/22/09, at 1:45 AM, a nurse documented that "isolation precautions maintained for MRSA in urine." On 1/27/09, a nurse documented that the resident had received an antibiotic "for MRSA to foot" without adverse effects. Review of the physician orders revealed Resident #22 was on Bactrim DS twice a day for chronic osteomyelitis. There was no medication ordered for a MRSA infection. Resident #21's medical record was reviewed and the discharge summary revealed the resident had nasal swabs that were positive for MRSA on 12/22/08. Review failed to reveal any additional testing for MRSA. Nursing documented on 1/13/09 the resident was on isolation precautions for MRSA in sputum. Review of the physician orders failed to reveal a medication ordered for a MRSA infection. On 1/28/09, the Infection Control Nurse was interviewed. Neither of these residents were on the infection control logs she kept. She explained there were two logs. One was for infections that were either nosocomial or community acquired. The second was for infections that the resident was being treated for but did not meet McGeer criteria for nosocomial infection. She explained	F 441		

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F 441	Continued From page 20 that she was alerted to infections in the facility through either the telephone orders for antibiotics or the 24 hour report. She did not know why either Resident #21 or #22 was not listed on the infection control log. She further explained that a low-risk roommate would be one with no open wounds, no intravenous lines, and no tubes (gastrostomy tubes or Foley catheter, for example). On 1/29/09, Resident #22 was observed to have moved to another room. The resident stated that he had been moved the previous evening. Interview with the RCM, Employee #8, revealed that Resident #22 was determined not to have MRSA in his wound. The resident's wound had healed to a hard scab and unable to be cultured. Employee #8 did not know why nursing had identified the resident as having MRSA in the urine. He stated as far as he knew, Resident #22 did not have MRSA of the urine on admission. The facility's policy for MRSA precautions was reviewed and revealed the following under Room Arrangements: "It is preferable for residents with MRSA to be cohorted (share a room or be in a specific area with MRSA residents) or they may share a room with a low-risk roommate (intact skin and no invasive devices)." Resident #21 was identified as being positive for MRSA in his sputum. Resident #22 was admitted to the same room as Resident #21. Resident #21 had a Foley catheter intact upon admission. Review of the facility census at the time of Resident #21's admission revealed there were empty rooms available.	F 441		

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F 441	Continued From page 21 Resident #20 was admitted to the facility on 3/21/08 with diagnoses that included muscle weakness, difficulty walking, cellulitis, hypertension, congestive heart failure, osteoarthritis, osteoporosis and hyperlipidemia. Review of Resident #20's medical record revealed a positive diagnosis of clostridium difficile (C-diff) on 1/25/09 and the resident was placed on Flagyl 250 milligrams every eight hours for seven days. The physician's progress note dated 1/26/09 documented " positive for urinary tract infection (UTI), positive for C-diff, and dehydration." On 1/27/08 an isolation cart was observed outside of Resident #20's room. No posting information was observed warning people to "stop" before entering the residents room. At 10:00 AM a certified nursing assistant (CNA) was observed in Resident #20's room without protective wear. At 1:00 PM visitors were observed in Resident #20's room without protective wear. An interview with a RN was conducted on 1/27/09 at 2:00 PM. She stated that Resident #20 was positive for C-diff and that "they gown up when doing any direct patient care, but otherwise it was okay to go into the room unprotected." It was observed that Resident #20 had a roommate. The RN was asked why Resident #20 had a roommate and the RN replied "we don't typically change resident rooms because Resident #20 is on bedrest." The RN and this surveyor put on protective wear and entered Resident #20's room. It was observed that there was no infectious waste	F 441		

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F 441	Continued From page 22 receptacle inside the room and no signs of discarded protective gowns were observed anywhere in the room. The RN approached Resident #20's bed and the resident looked startled. The RN stated to Resident #20 "it's okay, we just put on all of the gear this time." Review of the facilities policy and procedure on Infection Control for Clostridium Difficile revealed the following contact precautions: * Residents with diarrhea caused by C. difficile should be in private rooms or in the same room with other residents with C. difficile. If neither of the above rooming situations is available, review the specific resident situation to determine if a semi-private room with a low risk roommate is acceptable. * Gloves should be worn to enter the room of a resident who has diarrhea caused by C. difficile. * A gown is needed to enter the room of a resident who has diarrhea caused by C. difficile if substantial contact with the resident or environmental surfaces is anticipated. * Gowns and gloves should be removed before leaving the resident's room and hands must be washed immediately following hand hygiene guidelines. An interview was conducted on 1/28/09 with the Director of Nursing (DON), Infection Control Nurse (ICN), and Corporate Nursing Representative to discuss the facility infectious control practices. The ICN stated that Resident #20's roommate was not moved because she was a "low risk" resident and Resident #20 was on bedrest. The facility resident census on 1/25/09 allowed for a private room for the infectious resident.	F 441		

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F 441	Continued From page 23 Resident #28 was admitted to the facility on 10/5/07 with diagnoses including dermatitis/pruritis, cerebral vascular accident, muscle weakness, hypertension, depressive disorder, aphasia and speech disturbance. Review of Resident #28's medical record revealed a chronic history of dermatitis and pruritis with an order for Atarax 25 mg every 8 hours as needed for severe pruritus and Prednisone 10 mg every day. Resident #28 was diagnosed with a left jaw cellulitis on 11/25/08 and was treated with Keflex 500 mg every 8 hours for one week. On 1/5/09 Resident #28 was diagnosed with shingles and placed on Valtrex 1 gram three times daily for one week. Resident #28 was a roommate with a resident diagnosed positive for C. diff. An interview on 1/28/09 in the afternoon was conducted with the Director of Nurses, Infection Control Nurse (ICN), and Corporate Representative. The ICN stated Resident #28 was residing with another resident with a infectious disease because she was considered to be a "low risk" resident. The facility failed to provide what criteria they used to determine "low risk" but the ICN stated it was a resident "without any lines, tubes, or open skin." She stated "she did not feel Resident #28 was at increased risk based on these criteria." Review of the Infection Control Log revealed that neither the cellulitis or shingles infections were documented in the Log. The ICN stated "both infections must have been missed, but the two infections did meet the McGeer criteria and should have been entered into the log, tracked,	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 and trended."	F 441		
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review the facility failed to notify the physician of a laboratory report in a timely manner for 1 of 28 residents (#16). Findings include: Resident #16 was admitted on 1/14/09, with diagnoses including lumbar laminectomy and fusion, lumbar spinal stenosis, history of two cerebrovascular accidents and urinary tract infection. Resident #16's record review revealed that an entry made in the nurses notes dated 1/18/09 at 1:00 AM, indicated that the resident had "multiple" episodes of diarrhea. Record review revealed that on 1/18/09, the resident had been started on an antibiotic for possible clostridium difficile infection. On 1/19/09, a stool culture was ordered. Resident #16's record review revealed that a lab report received on 1/20/09 at 2:00 PM, indicated that the resident did not have a clostridium difficile infection. Record review further revealed that the physician ordered the antibiotic to be discontinued on 1/26/09.	F 511	**F 511** I) Resident #16 has been discharged home. II) Residents with current lab orders will be audited for timely physician notification. III) Nursing to be educated regarding timely physician notification. See exhibit 4. A call log has been implemented for timely physician notification. See exhibit 31. IV) Resident Care Managers or designee will perform random audits weekly to ensure timely physician notification of lab results. See exhibit 32. Audit findings to be reported to Performance Improvement Committee on a monthly basis until threshold is met. See exhibit 33. V) Director of Nurses. VI) March 13, 2009	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295050	A. BUILDING _____ B. WING _____	01/29/2009

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F 511	Continued From page 25 Resident care manager #4 was interviewed and reported that the lab report should have been placed in the "communication book" for the physician to review the following day. She reported that a nurse should have called the physician because Resident #16 was being treated with antibiotics with no indication. She further reported that she did not know why the lab report was missed. When asked what was the facility's policy related to physician notification of lab reports, she reported that the use of the communication book was not in a written policy, but that the nurses know that they are to use the book, or call the physician if necessary. Cross reference F 441	F 511		